STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155543	A. BUILDING 00 B. WING	06/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT HUNTINGTON	1425 GRANT ST HUNTINGTON, IN46750

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F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint # IN00092175. Complaint # IN00092175- Substantiated. Federal/state deficiencies related to the allegations are cited at F441. Survey dates: June 20, 21,22,23, 2011 Facility number: 000346 Provider number: 155543 AIM number: 100288320 Survey team: Vicki Bickel, RN-TC Debora Barth, RN Census bed type: SNF/NF: 33 Total: 33 Census payor type: Medicaid: 32 Other: 1 Total: 33 Sample : 10 These deficiencies reflect state findings	F0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at Huntington desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on July 15, 2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	cited in accordance with 410 IAC 16.2. Quality review completed on June 27, 2011 by Bev Faulkner, RN			
F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to notify the physician of a condition change for 1 of 10 residents (	F0157	This Plan of Correction constitutes the written allegation of compliance for the deficiencies	07/15/2011

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	Resident #12) reviewed for physician notification in a sample of 10. Finding includes: Resident #12's clinical record was reviewed on 6/20/11 at 2:10 p.m. Diagnosis included but were not limited to: schizophrenia, chronic paranoia, chronic obstructive pulmonary disease, hypertension, coronary artery disease, and tardive dyskinesia. The "Nurses Notes," dated 4/4/11 at 5:45 a.m., indicated Resident #12's oxygen saturation (Sa02) was checked, due to shallow respirations, and found to be 83% on room air. "As needed" oxygen was applied, per previous order. No further oxygen saturation (SaO2) levels were taken at that time. On 4/4/11 at 9:00 a.m., the "Nurses Notes" indicated the residents SaO2 level to be at 91% on 2 LPM (liters per minute). Vitals signs were blood pressure 148/72, pulse 136, respirations 18, temperature 98.0 degrees. No other assessment was completed. At 10:25 a.m., on 4/4/11 a physician's order was received for labs to be drawn with next lab draw and obtain urinalysis. There was no mention of the physician		cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at Huntington desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on July 15, 2011. F157 It is the policy of this facility to notify attending physicians and families/legal representatives of resident status changes immediately upon observation. What corrective action will be done by the facility?No further omissions of physician or family/legal representative notification have been identified. The Director of Nursing or Designee will review the twenty-four hour report and focused charting at least five days each week to ensure notifications are completed.Licensed Nurses will be inserviced on July 7 and July 8, 2011 by the Director of Nursing on the importance of immediate notification of the attending physician and families/legal representatives when a resident condition changes. Following the inservice, any nurse who fails to follow the correct procedure of notification will be re-inserviced and progressive disciplinary action rendered.How will the facility identify other residents having the	

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	being notified of the SaO2 earlier in the a.m., in the "Nurses Notes." At 12:00 p.m., an order clarification was written for O2 (oxygen) mask at 2 LPM to keep O2 Saturation above 88%. Again, no indication in the "Nurses Notes" the physician was notified of the low oxygen saturation level. The "Nurses Notes," dated 4/4/11 at 2:25 p.m., indicated the residents SaO2 level was at 84% after lunch. The oxygen mask was applied at 2 LPM with SaO2 levels returning to 92%. At 7:00 p.m., on 4/4/11 the "Nurses Notes" indicated the resident's SaO2 levels to be at 92%-94% with O2 at 2 LPM. On 4/5/11 at 1:30 a.m., SaO2 was 92% per "Nurses Notes". On 4/5/11 at 9:30 a.m., the "Nurses Notes" indicated the resident was lethargic. SaO2 levels were 92% on 2LPM via nasal cannula. The "Nurses Notes," dated 4/5/11 at 11:00 a.m., indicated the resident's" breath sounds were coarse through-out bilateral lobes. An as needed respiratory treatment was given. O2 Saturation was 92%,		potential to be affected by the same practice and what corrective action will be taken?All residents have the potential to be affected. No residents were found to be negatively affected.What measures will be put into place to ensure this practice does not recur?The Director of Nursing or Designee will review focused charting and the twenty-four hour report at least five days per week prior to the morning meeting. Any change of resident condition will be reviewed by the Interdisciplinary Team including the Administrator at that meeting to ensure notifications were completed. Any licensed nurse who fails to complete required notifications will be re-inserviced and progressive disciplinary action rendered as deemed necessary. Review of the nursing focused charting and twenty-four hour report is an established, ongoing responsibility of the Director of Nursing. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? Results of the focused charting and twenty-four hour report review will be forwarded to the monthly QA&A committee for further review for 90 days and until 100% compliance is obtained. The QA&A committee will then determine the need for further monitoring.Date of Compliance: July 15, 2011	

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	pulse 112, respiration 18 and irregular. Resident weak right lower extremity elevated warmth and redness resident responds with verbal stimulation though delayed". The physician was notified at this time and an order for an immediate chest x-ray was received, along with an order for an antibiotic to be started. At 9:55 p.m. on 4/5/11, a call was placed to the physician regarding the resident's condition per "Nurses Notes." At 10:15 p.m., on 4/5/11 an order was received to send the resident to the local emergency room for evaluation and treatment. The resident was admitted to the local hospital on 4/6/11 at 2:21 a.m., with diagnosis of "acute mental status changes, urinary tract infection with possible urosepsis, and hypercarbia (high carbon dioxide in the blood), which is improving". An interview with the Director of Nursing on 6/21/11 at 11:05 a.m., indicated she was unsure of why the resident was not fully assessed. The initial thought was that the resident had cellulitis in her right lower extremity and that was why the			

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	antibiotic was ordered. She also indicated the urinalysis report prompted the physician to be called but there was no documentation. The facility policy and procedure dated 6/2004, received and reviewed on 6/21/11, indicated " the resident's primary physician....will be notified immediately of any change in the resident's physical or mental condition. Examples of significant change include, but are not limited to: .....Signs and symptoms of infection." 3.1-5(a)(2)			
F0328 SS=D	The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on interview and record review, the facility failed to provide respiratory	F0328	F328It is the policy of this facility to administer treatments and	07/15/2011

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	assessment and nebulizer treatments for 1 of 1 residents (Resident #12) reviewed for specialized respiratory care in a sample of 10. Finding includes: Resident #12's clinical record was reviewed on 6/20/11 at 2:10 p.m. Diagnosis included but were not limited to: schizophrenia, chronic paranoia, chronic obstructive pulmonary disease, hypertension, coronary artery disease, and tardive dyskinesia. Physician orders included "as needed" orders for oxygen and albuteral via nebulizer. The "Nurses Notes," dated 4/4/11 at 5:45 a.m., indicated Resident #12's oxygen saturation (Sa02) was checked, due to shallow respirations, and found to be 83% on room air. "As needed" oxygen was applied (from a previous order). No further oxygen saturation (SaO2) levels were taken after the application of the oxygen nor did the "Nurses Notes" indicate the oxygen flow rate. On 4/4/11 at 9:00 a.m., the "Nurses Notes" indicated the resident's SaO2 level to be at 91% on 2 LPM (liters per minute). Vitals signs were blood pressure		special services as ordered by the attending physician. What corrective action will be done by the facility? Resident #12 is receiving nebulizer treatments as ordered and respiratory assessments have been completed as indicated.Licensed Nurses will be inserviced by the Director of Nursing on July 7 and July 8, 2011 on correct assessment of residents requiring PRN oxygen or nebulizer treatments.Following the inservice presentation, any nurse who fails to follow the procedure for administering treatments as ordered and completing appropriate assessments will be re-inserviced and progressive disciplinary action will be rendered as deemed necessary.How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?All residents have the potential to be affected, no other residents were found to be negatively affected. What measures will be put into place to ensure this practice does not recur? The Director of Nursing or Designee will review focused charting and the twenty-four hour report at least five days a week prior to morning meeting to determine if any resident required PRN oxygen or nebulizer treatments. The medical record of any resident requiring PRN oxygen or	

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	148/72, pulse 136, respirations 18, temperature 98.0 degrees. No other assessment was completed. At 10:25 a.m., on 4/4/11 a physician's order was received for labs to be drawn with next lab draw and obtain urinalysis. No mention of the physician being notified of the SaO2 earlier in the a.m. in the "Nurses Notes." At 12:00 p.m., an order clarification was written for O2 (oxygen) mask at 2 LPM to keep O2 Saturation above 88%. Again, no indication in the "Nurses Notes" the physician was notified of the low oxygen saturation level. The "Nurses Notes," dated 4/4/11 at 2:25 p.m., indicated the resident's SaO2 level was at 84% after lunch. The oxygen mask was applied at 2 LPM with the SaO2 levels returning to 92%. At 7:00 p.m., on 4/4/11 the "Nurses Notes" indicated the resident's SaO2 levels to be at 92%-94% with O2 at 2 LPM. On 4/5/11 at 1:30 a.m., SaO2 was 92% per "Nurses Notes." On 4/5/11 at 9:30 a.m., the "Nurses		nebulizer treatments will be reviewed by the interdisciplinary team including the Administrator at the morning meeting to ensure appropriate assessment and follow up was completed. Review of the nursing focused charting and twenty-four hour report is an established, ongoing responsibility of the Director of Nursing. Review of the Medication Administration record and Treatment record will be completed five days per week for four weeks, three days per week for four weeks and then weekly for four weeks. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?Results of monitoring the medication administration record and treatment records will be forwarded to the QA&A committee for further review. After 90 days and 100% compliance is obtained, the QA&A committee will determine the need and frequency of further monitoring.Date of Compliance: July 15, 2011	

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	Notes" indicated the resident was lethargic. SaO2 levels were 92% on 2 LPM via nasal cannula. The "Nurses Notes," dated 4/5/11 at 11:00 a.m., indicated the resident's breath sounds were coarse through-out bilateral lobes. An "as needed" respiratory treatment was given per previous order. The "Respiratory Breathing Assessment/Treatment Log" for April 2011, indicated the first respiratory treatment and assessment was completed on 4/5/11 at 11:00 a.m. This was the only treatment the resident received until after readmission from the hospital. An interview with the Director of Nursing on 6/21/11 at 11:05 a.m., indicated she was unsure of why the resident was not fully assessed. 3.1-47(a)(6)			

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F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to assure 1 of 10 residents receiving psychoactive medications in a sample of 10 residents was evaluated for medication reduction while he had been receiving seven psychoactive medications for an unknown amount of time. (Resident # 6) Findings include: The clinical record for Resident # 6 was reviewed on 6/20/11 at 10:30 a.m. The resident had been admitted on 3/23/11 with diagnoses which included, but were not limited to: bipolar disorder, anxiety,	F0329	F329 It is the policy of this facility to ensure each resident's drug regimen will be free from unnecessary drugs. What corrective action will be done by the facility? An appointment has been set for July 14, 2011 where resident #6 will be evaluated by a psychiatric consultant including medication review. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? The Director of Nursing has reviewed the medical record of all residents receiving antipsychotic medications. All residents have had attempts at gradual dose reductions unless it	07/15/2011

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	impulse control disorder, chronic obstructive pulmonary disease, high blood pressure, and glaucoma. The physician orders were reviewed. The resident was receiving the following psychotropic medications: Thorazine 25 mg (milligrams) four times daily, Seroquel 300 mg twice daily and 200 mg once daily, Prolixin 7.5 mg twice daily and 10 mg at bedtime, and Zyprexa 10 twice daily. In addition he was receiving Buspar 20 mg four times a day and Ativan 1 mg twice daily and 2 mg at bedtime for anxiety. He was also receiving Lithium 450 mg three times each day for his bipolar disorder. The orders had been signed by a medical doctor and reviewed by a psychologist. The resident was being tracked for behaviors which included "manipulative behaviors, verbal aggression, refusal of care, exit seeking, non-compliance with facility smoking policy, knocking on and standing in others doorways to gain staff attention, taking other drinks/food, and physical aggression." The behavior log and nursing notes indicated the resident had displayed all of these behaviors since having been admitted to the facility in March, 2011. His physical aggression had resulted in him hitting and kicking a door after he was told he would have to wait		has been documented by the attending physician that a gradual dose reduction is contraindicated.The pharmacy consultant reviews medication regimens monthly to ensure gradual dosage reductions follow established guidelines.What measures will be put into place to ensure this practice does not recur? The Director of Nursing will audit all newly obtained Physician orders for antipsychotic medications to ensure there is a diagnosis to support its use. The audits will be completed five days per week for four weeks, three days per week for four weeks and then weekly for four weeks. Audit results will be forwarded to the Administrator for review.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?The Director of Nursing audit results will be reviewed at the monthly QA&A committee meeting for 90 days and until 100% compliance is obtained. Further audits will be completed as recommended by the QA&A committee.Date of Compliance: July 15, 2011	

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	for his ice since he was on a water restriction. The Minimum Data Set assessment, completed on 3/29/11, indicated the resident was independent with all of his activities of daily living except hygiene. He was ambulatory. He weighed 241 pounds and was 71 inches tall. Interview with the Director of Nursing (DoN) on 6/22/11 at 1:45 p.m., indicated the resident had not been seen by a psychiatrist. She also indicated she was not aware of how long the resident had been taking all these medications at these dosages. The resident had been admitted from an inpatient psychiatric hospital which was not in the area. She also indicated she was not sure what behaviors had necessitated the use of these medications. She indicated she had spoken to the psychologist who had reviewed the resident's record. The psychologist indicated he would refer the resident to a psychiatrist if he needed one. 3.1-48(b)(2)			

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F0406 SS=D	If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. Based on record review and interview, the facility failed to ensure specialized mental health services for psychiatric management of psychotropic medications as recommended by the Level II Screening Evaluation was followed for 1 of 10 residents with MR/MI diagnoses in a sample of 10 residents. (Resident # 6) Findings include: The clinical record for Resident # 6 was reviewed on 6/20/11 at 10:30 a.m. The resident had been admitted on 3/23/11 with diagnoses which included, but were not limited to: bipolar disorder, anxiety, impulse control disorder, chronic obstructive pulmonary disease, high blood pressure, and glaucoma. The Level II Preadmission Screening Evaluation was completed on 3/5/11. There were nine different recommendations made at that time. The	F0406	F406 It is the policy of this facility to provide specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, as required. What corrective action will be done by the facility?Resident #6 has a scheduled appointment for psychiatric services on July 14, 2011.How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?All residents with Level II Screening Evaluations have the potential to be affected. Level II Screening Evaluations were reviewed to ensure recommendations for psychiatric services are being followed. No other residents were affected.What measures will be put into place to ensure this practice does not recur?The Social Services Director or Designee will review all Level II	07/15/2011

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HICKORY CREEK AT HUNTINGTON	1425 GRANT ST HUNTINGTON, IN46750

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	recommendations included: "...4. It is recommended that (Resident # 6's name) receive regular psychiatric management of his psychotropic medications...." The physician orders were reviewed. The resident was receiving the following psychotropic medications: Thorazine 25 mg (milligrams) four times daily, Seroquel 300 mg twice daily and 200 mg once daily, Prolixin 7.5 mg twice daily and 10 mg at bedtime, and Zyprexa 10 twice daily. In addition he was receiving Buspar 20 mg four times a day and Ativan 1 mg twice daily and 2 mg at bedtime for anxiety. He was also receiving Lithium 450 mg three times each day for his bipolar disorder. The orders had been signed by a medical doctor and reviewed by a psychologist. The resident was being tracked for behaviors which included "manipulative behaviors, verbal aggression, refusal of care, exit seeking, non-compliance with facility smoking policy, knocking on and standing in others doorways to gain staff attention, taking other drinks/food, and physical aggression." The behavior log and nursing notes indicated the resident had displayed all of these behaviors since having been admitted to the facility in March, 2011. His physical aggression had resulted in him hitting and kicking a door		recommendations at the time the Level II is received to ensure recommendations are not omitted. Follow-up review of the Level II will be completed quarterly and with the annual MDS. The Social Service Consultant will begin facility visits every two months beginning on August 11, 2011. Results from this visit will be reviewed by the Social Service Designee and the Administrator, and then forwarded to the QA&A committee for further recommendations. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?A list of residents with a completed Level II will be reviewed at theat the QA&A meeting. After 90 days and 100% compliance the QA&A committee will determine the need and frequency of further monitoring.Date of Compliance: July 15, 2011	

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	after he was told he would have to wait for his ice since he was on a water restriction. Interview with the Director of Nursing (DoN), on 6/22/11 at 1:45 p.m., indicated the resident had not been seen by a psychiatrist. She also indicated she was not aware of how long the resident had been taking all these medications at these dosages. The resident had been admitted from an inpatient psychiatric hospital which was not in the area. She indicated she had spoken to the psychologist who had reviewed the resident's record. The psychologist indicated he would refer the resident to a psychiatrist if he needed one. 3.1-23(a)(2)			

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview and record review, the facility failed to maintain infection control practices for 1 of 1 residents (Resident C) observed for catheter/pericare in a sample of 10.	F0441	F 441 It is the policy of this facility to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent	07/15/2011

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	Finding includes: Resident C's clinical record was reviewed on 6/20/11 at 10:45 a.m. Diagnosis included but were not limited to: dementia, hypertension, depression, Paget's disease, anemia, esophageal reflux disease, and Stage III pressure ulcer. An observation was conducted on 6/21/11 at 2:02 p.m., of Resident C receiving catheter/pericare. The resident was turned to her left side while lying in the bed. She was observed to have a loose dressing covering her pressure ulcer which was located on the medial aspect of her right buttock. Certified Nursing Assistant (CNA) #1 was handed a very wet wash cloth from CNA #2. CNA #1 held the wet wash cloth close to the resident's buttock and squeezed the water from the wash cloth down over the resident's buttock, including over and under the loose dressing. She then wiped the resident's buttocks with the wash cloth but not near the loose dressing. She also washed the resident's anal area and then dried the entire bottom area with a dry towel. The CNA's did not report to a licensed nurse that the dressing was loose and had become wet during care.		the development and transmission of disease and infection. What corrective action will be done by the facility? Nursing staff will be inserviced by the Director of Nursing on July 7 and July 8, 2011 to review the correct procedures for catheter care and peri-care. Nursing staff will then perform a return demonstration using proper technique following the established policies.How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All residents have the potential to be affected; no other residents were negatively affected. What measures will be put into place to ensure this practice does not recur?Random observations of peri-care/catheter care will be completed by the Director of Nursing or Designee five times per week for four weeks, then three times per week for four weeks, then one time per week for four weeks. An employee who fails to follow the correct procedure will be re-inserviced and progressive disciplinary action rendered as deemed necessary. Results of the observations will be reported to the Administrator. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?Results of the observations will be forwarded to	

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	The resident was then rolled onto her back, dressed and assisted to her wheelchair. Both CNA's were interviewed after completion of the care as to whether they would have done anything differently. They both replied "No." The Director of Nursing was present at this interview. An interview with the Director of Nursing, on 6/21/11 at 2:20 p.m., indicated the CNA's had not followed procedure and this was an infection control issue with the resident having an open wound on her buttock. She would assure that the dressing was changed quickly. The policy and procedure, dated 5/05, received and reviewed on 6/21/11 indicated to wash from front to back and from center to thighs, using a different part of the washcloth for each stroke. Cleansing and then drying from front to back. This Federal tag relates to Complaint # IN00092175. 3.1-18(b)(1)		the monthly QA&A committee for further review and recommendations. When observations have been completed for twelve weeks and 100% compliance has been obtained, the QA committee will determine the need and frequency for further observations.Date of Compliance: July 15, 2011	

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